DOCUMENT RESUME

ED 243 027 CG 017 395

AUTHOR Adelman, Howard S.; And Others
TITLE Children's Participation in Consent for Psychotherapy and Their Subsequent Response to Treatment.
PUB DATE Aug 83
NOTE 44p.; Paper presented at the Annual Convention of the American Psychological Association (91st, Anaheim, CA, August 26-30, 1983). Best copy available.
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adjustment (to Environment); *Adolescents; *Children; Competence; *Counseling Effectiveness; *Decision Making; Elementary Secondary Education; Motivation; *Participation; *Psychotherapy; Responses
IDENTIFIERS Commitment; *Informed Consent

ABSTRACT

Referral and initiation of psychotherapy for children and adolescents are decisions most frequently made by others. To investigate the nature of minors' participation in treatment decision making and the relationship between such participation and motivation, adjustment, and outcomes, the behaviors and attitudes of 42 youths (32 male, 10 female, median age, 15), participating in a special education laboratory program on a university campus, were studied before, during, and at the end of psychological treatment. Each participant took part in a two-phase informed consent interview prior to treatment. Forms of measurement used to elicit indices of commitment, motivation, and negative behavior included: ratings; regular reports of observed classroom behavior; and structured and open-ended questions. An analysis of the results showed that despite apparent competence to participate, only seven youngsters were involved in the processes during which psychological treatment was prescribed for them. Moreover, while 75 percent of the sample directly consented to treatment, only 60 percent indicated strong interest in getting started, and only 31 percent were evaluated as motivationally ready to begin. A positive relationship was found between clients' motivational readiness and treatment adjustment and outcomes. (Author/BL)

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Children's Participation in Consent for Psychotherapy and their Subsequent Response to Treatment

Howard S. Adelman, Nancy Kaser-Boyd, and Linda Taylor

University of California, Los Angeles

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Abstract

Children's Participation in Consent for Psychotherapy

and their Subsequent Response to Treatment

This clinical study focused on minors' participation in decisions to enter psychotherapy and on how such participation and other motivational factors relate to responsiveness to treatment. Findings indicate that, despite apparent competence to participate, few of the 42 youngsters sampled had been involved in the processes during which psychological treatment was prescribed for them. Moreover, while 75% of the sample directly consented to treatment, only 60% indicated strong interest in getting started, and only 31% were evaluated as motivationally ready to begin. A positive relationship was found between clients' motivational readiness and treatment adjustment and outcomes. The literature reviewed and discussion of findings underscore the potential impact of nonparticipation on commitment to, adjustment in, and outcomes of psychological treatment.

Children's Participation in Consent for Psychotherapy and their Subsequent Response to Treatment

Referral and initiation of psychotherapy for children and adolescents are decisions nearly always made by others (e.g., parents, school and social service personnel, judges). This is not surprising since minors involved in behavior considered deviant often are not interested in or willing to seek treatment. There also is the question of whether minors, in general, have the competence to make appropriate decisions about such matters. The widespread trend of making treatment decisions for minors, of course, is but one aspect of a broader set of legal and moral obligations that parents and agents of society have for facilitating children's development and socialization. At the same time, this trend raises a variety of legal, ethical, and practical issues for psychotherapists and counselors (Adelman & Taylor, 1983; Melton, Koocher, & Saks, 1983; Wilson, 1978).

One perspective on the topic of minors' participation in psychotherapy decision making comes from research on current professional attitudes and practices and on client attitudes. With regard to client attitudes, findings from three recent studies suggest that the majority of children and adolescents and their parents (representing samples of minors with and without problems) want minors to participate in therapy decision making. Moreover, the majority of those surveyed indicated that minors, at least beginning at ages 13-14, should make their own decisions

about psychotherapy (Taylor, Adelman, & Kaser-Boyd, in press-a; in press-b; Tremper & Feshbach, 1981). Therapists are found to be more divided on the matter. In a survey of mental health professionals working with minors, less than half (87 out 182) of those who responded report including individuals under 18 in informed consent procedures. Among those who do seek minors' participation, the majority indicate they do so in order to enhance motivation and therapeutic relationships. They also report that approximately one-third of the minors asked tend to refuse treatment and that about 25% do not seem to have the competence to understand and provide valid informed consent (Taylor, et al, in press-b).

Attitudes underlying practices that establish age guidelines for involvement of individuals in decision making often are discussed with reference to the concept of competence. Most researchers interested in competence to decide have drawn from Piaget's description of stages of cognitive development. There is general agreement that children who have reached the stage of formal operations are competent to make important decisions (e.g., they are able to imagine where each of two or more possible courses of action lead). Research suggests that formal operational thinking begins to appear at about age 11 and reaches equilibrium by about age 14 (Weithorn & Campbell, 1982). In this connection, it has been found, with regard to psychological and other health treatment situations, that 14 year olds may reason as effectively as older individuals (Keith-Spiegel & Maas, 1981; Weithorn, 1982); however, differences have been reported

regarding attributions underlying decisions and understanding of future considerations (Lewis, 1980). Investigators also have reported (a) a positive relationship between socioeconomic status and the age at which children are aware of their rights (Melton, 1980) and (b) a tendency among some adolescents toward an external locus of control and deference which may interfere with independent decision making up to about age 14 (Distefano, Pryer, & Smith, 1971; Grisso & Vierling, 1978).

Besides considerations of competence, a major concern related to involving minors in decision making is the possibility they will experience negative effects (Kenny, 1977; Koocher, 1976; Vardin & Brody, 1979; Wilson, 1978). Some professionals warn that most children simply are not mature enough to make important choices and still need adult protection or else they will make irrevocably harmful decisions (Baumrind, 1978). Miller and Burt (1982) emphasize this as a possibility, especially when youngsters are faced with decisions about psychiatric hospitalization. They suggest that refusals are likely to be prevalent among adolescents because of a strong age-related tendency to act out against authority. Even while highlighting benefits, writers have acknowledged that children's participation in treatment decisions could have negative effects (e.g., Graziano & Fink, 1973; Melton, 1983; Weithorn, 1983). Prominent among the potential negative consequences are (a) increasing a child's anxiety, (b) negatively affecting self-concept, (c) setting self-fulfilling prophesies into motion, and in general, (d) exacerbating the individual's problems. Such effects are

seen as arising because children involved in decision processes may experience information overload, major dilemmas in attempting to choose among difficult options, heightened awareness of their problems, antagonism from adults who do not want children included, and so forth.

In contrast, frequently discussed negative consequences of not allowing for participation in treatment decisions include the possibility that mandated psychological treatment will not be pursued and involuntary treatment will be resisted and thus be ineffective (Nir & Cutler, 1978; Oxley, 1977). More affirmatively, advocates for involvment of minors in treatment decision making have stressed legal and ethical rights of clients and the psychological benefits of such participation. In this last connection, a large body of experimental studies has been interpreted as suggesting that commitment, motivation, and performance (including resistance and reactance behavior) are related directly to the degree to which individuals experience choice, control, or self-determination (e.g., see Baum & Singer, 1980; Deci, 1980; Deci & Ryan, 1982; Perlmuter & Monty, 1979).

While much of the research has been done under laboratory conditions, using paper and pencil measures to asssess short-term outcomes, some clinical studies have been reported. Cognitive therapy studies suggest that clients' perceptions of self-determination in connection with therapy strategies can lead to greater behavior changes during treatment (Wilson, 1979) and improvement in the maintenance of behavior changes (Kopel &

Arkowitz, 1975). The rate of follow through on initial calls to schedule therapy intake is bolstered by giving the potential clients a choice of therapy modalities (Eisner-Hershfield, Abromowitz, & Baron, 1979). In residential treatment with elderly populations, several investigators have reported dramatic relationships between client well-being and opportunities for self-determination, e.g., choice and control (Rodin & Langer, 1977; Schulz, 1976; Schulz & Hanusa, 1978).

Most relevant to the research reported here are studies with child and adolescent samples. Holmes and Urie (1975) found drop out rates were reduced significantly by providing minors with preliminary information about psychotherapy. Lewis, Lewis, Lorimer, and Palmer (1977) found that when children were allowed to make their own decisions about seeking out the school nurse, they showed decreased vulnerability, perceived their problems as less severe, and increased their belief in the value of self-care. Based on a clinical study, Janzen and Love (1977) report an intervention where acting out in treatment was significantly reduced among a group of adolescent girls when they were allowed to take an active role in planning and evaluating major facets of their treatment. In a study of noncompulsory vs. mandated placement among adolescents, Bastien and Adelman (1983) found significant relationships between response to treatment and the use of informed consent procedures and perceptions of choice about remaining in treatment.

Findings on involuntary treatment, however, have been mixed.

Some studies report mandated programs to be unsuccessful and frustrating (e.g., Robison & Smith, 1971); others report compulsory treatment to be helpful and even satisfying (e.g., Oxley, 1977). Most studies suggesting a positive impact of mandated treatment, however, simply show that individuals ordered into treatment by a judge stay in programs longer than those who enter such treatments voluntarily (e.g., Freedberg & Johnston, 1978; Gossip, 1978).

As the above brief review suggests, there is a considerable need for clinical research that can help clarify the nature of (a) minors' participation in treatment decision making, (b) the connection of such participation to motivational readiness for therapy, (c) the relationship between initial adjustment in treatment and specific demographic, motivational, and other attitudinal antecedents, and (d) the relationship between specified antecedent and initial adjustment variables and short-term treatment outcomes. That subgroup of youngsters who are reluctant to participate are of particular interest in this connection. The work reported here is part of a larger project focusing on these matters.

Method

The research involved (1) a survey of available records on the referral processes for each minor in the sample, (2) observation and investigation prior to treatment of reactions to the idea of participation in the prescribed psychological treatment and of concurrent behavior in a special educational treatment program,

(3) monitoring of intitial adjustment in psychological treatment, and (4) evaluation of short-term outcomes.

Sample

Participants were 32 males and 10 females attending a laboratory school program on a University campus. The Los Angeles based facility accepts children and adolescents referred by mental health professionals, parents, and local public school districts. The problems leading to referral include learning and behavior (encompassing socio-emotional and motivational) problems. Data from available records on the 42 participants indicate that 11 had been labeled as behavior disordered, 9 as seriously emotionally disturbed, and 7 as learning disabled; 11 had not been asssigned to a diagnostic category. All participants had been through processes designed to screen out those who were not of at least average intelligence.

Ages ranged from 10-19 (median = 15). Ethnic representation was 19 Anglo, 20 Black, and 3 Hispanic. Using procedures specified by Hollingshead (1975), the majority of participants can be described as from upper middle income backgrounds, with 17% from lower SES and 21% from lower middle SES families. Length of time in the special school program ranged from 2 weeks to 45 months with a median of 16 months. The majority (73%) had been in psychological treatment previously (50% at the facility where the study was conducted). Referral for psychological treatment was made by public school personnel as part of the participant's Individual Education Plan (IEP) in 35 cases; of the

remaining 7, 5 were referred by self and 2 referred by a teacher in the laboratory school program. The other 20 minors in the school program were not involved in therapy and did not participate in the study.

With regard to fluctuations in the sample, it may be noted that 3 youngsters immediately indicated no interest in psychological treatment or in responding to any questions. Of the remaining 39, there were fluctuations in willingness to answer some questions during each phase of the investigation.

Measures and Procedures

Measures focused on youngsters' behavior and attitudes prior to, early in, and at the end of treatment. Forms of measurment included ratings, regular reports of observed classroom behavior, structured and open ended questions, and combinations of the above used to generate more complex indices of commitment, motivation, and negative behavior. Key measures not evident from the following discussion are summarized in Table 1. (More detailed information is available on request.)

Insert Table 1 about here

The project spanned most of an academic year. Available school records were reviewed to identify the nature of the processes by which youngsters were referred for psychological treatment.

Beginning in October, a staff psychologist met individually with all referred youngsters for an extended informed consent interview, lasting approximately 15-30 minutes. This interview had two stages, a phase to provide basic information about the general nature of the available psychological treatment and a phase designed to determine whether the youngster wanted to participate in such treatment. Three potential participants refused to even talk about the possibility of consenting to psychological treatment. After some initial cooperation, several others indicated they wanted to return to their classrooms and were allowed to do so.

After completing the first stage of the informed consent interview, the psychologist asked the youngster "Do you think, from what I said and what you already know about counseling, that you understand what would happen?" If the response was affirmative, she said "I want to be certain you understand. In your own words, please tell me what you think counseling is." If the description was vague or inaccurate (or if the initial response was negative), the basic information was repeated and amplified, first verbally and then, if necessary, through a 5 minute videotape presentation of a simulated therapy session.

A structured questionnaire containing four factual items (based on the specific information presented by the psychologist) then was administered.

At this point in the process, the psychologist made covert ratings of the youngster's apparent ability to understand the

material discussed and adequacy of communication. The ratings were based on the observed ease or difficulty with which the material was grasped and the youngster's performance in communicating throughout the interview.

The interview concluded with the psychologist asking for the youngster's decision regarding participation in treatment. It was stressed that there was a choice about the matter; it also was indicated that a trial program could be implemented if (s)he was uncertain. Those who responded affirmatively or conditionally were told they would be contacted by a therapist.

The day after their informed consent interview youngsters were contacted individually by a research assistant who explained he was conducting a study regarding individuals' reactions to the idea of participating in counseling. Each was asked about willingness to help by answering a few questions. All but 4 of the original 42 agreed to help; six others declined to answer a substantial portion of the questions. The structured interview included ratings of perceived choice and other antecedent attitudes toward psychological treatment and open ended questions providing additional data on the individual's understanding of the purposes of such treatment. At the end of the interview, the research assistant rated the youngster's understanding of verbal communication and adequacy of communication during the session.

For those youngsters who declined to participate in treatment, a follow-up interview was held to clarify their reasons. In addition, parents were contacted to discuss their view of the

youngster's decision and to discuss next steps and alternative courses of action. (The facility's policy precludes coercing youngsters into participating in psychological treatment; instead efforts are made to help solve problems through alternative, noncoercive steps; see Adelman and Taylor, 1983.)

Additional ratings of a youngster's understanding of verbal communication and adequacy of communication were elicited from the classroom teacher prior to therapy and from the therapist early in treatment.

Data on attitudes and behavior manifested in the classroom program were collected from administrative and teacher reports and teacher ratings generated during the week prior to initiation of psychological treatment and during the final week of treatment. Teachers had been instructed in how to monitor and record desired data and had done so continuously for over a year.

Data on initial adjustment (after 4-6 sessions) and short-term (end of treatment) outcomes were collected by research assistants during individual interviews where a therapist/client rated the specified variables.

Results and Discussion

For convenience of presentation, results are organized around 5 sequential questions and commented on in turn.

Question 1: What role did minors play in referral processes?

The focus here is on how many minors participated in decisions about psychological treatment. Reports on the processes by which youngsters were referred provided data on this matter.

Participation in decision making. Of 42 referrals for psychological treatment, records show 37 were recommended by school personnel or by parents; 5 were self-referred. Of the 37, treatment had been prescribed for 35 of them during the Individual Education Planning (IEP) process. Of the 35, 28 (80%) were not included in decision making processes, e.g., did not attend the meeting at which the decision was made.

Among the 7 (20%) who did attend the IEP meeting, none were younger than 15 (the age range was 15-17). At the meeting, the position taken by 6 of the 7 was that they did not want psychological treatment. Only 1 of these minors was able to get the recommendation deleted from the IEP prescription; he was subsequently referred to treatment by his parents.

Comments. The data on the referral processes clearly show that (1) a large majority of the youngsters were not included in decision making about the prescribed psychological treatment, (2) those who were included were all older adolescents, and (3) inclusion had little effect on outcomes. Based on our experiences, these findings are not surprising or atypical. Despite efforts to change attitudes about the matter, many adolescents and most children continue to be viewed as incompetent to participate in making decisions regarding major treatment prescriptions.

Question 2: Are minors competent to participate in decision making?

Basic to concerns about children's competence to participate in decisions is their ability to weigh risks, benefits, and outcomes of several courses of action. To assess such competence unobtrusively, minors were observed during various "real-life" interactions. Ratings were made of their ability (a) to understand what is discussed and (b) to communicate their views. (In a parallel, analogue study, minors were asked directly to evaluate psychotherapy risks, benefits, and outcomes, Kaser-Boyd, Adelman, & Taylor, 1983).

Competence to understand. Youngsters' answers on a 4 item questionnaire about the purposes of therapy and on self-reports and four sets of ratings of understanding (by teacher, psychologist doing the informed consent interview, research assistant, and therapist) all converge in indicating that most of the youngsters understood basic features of the psychotherapy sessions and the reasons they were referred. Of the 37 who responded, 86% answered all 4 questions correctly. These figures parallel the youngsters' self-reports of understanding. That is, during the informed consent process, 88% (36 of 39) responded affirmatively to the direct question "Do you understand what would happen in counseling?" On a 4 point scale where they rated their degree of understanding of what goes on in counseling, the mean rating was 3.1 (SD=.9). This pre therapy rating is consistent with a rating, elicited during treatment, of the amount of time they felt they understood what was going on in the

therapy sessions X=3.4 (SD=.8).

Independent ratings of understanding made by the psychologist during the informed consent interview and by the research assistant following up on the informed consent process indicate means of 3.3 (SD=.7) and 3.5 (SD=.6), respectively. These are consistent with the youngsters' self-ratings and the classroom teachers' concurrent ratings of general understanding of verbal communication ($\bar{X}$=3.2, SD=.7) and the subsequent ratings made by the therapists in the early stages of treatment ($\bar{X}$=3.4, SD=.6). Computation of the percent of agreement among raters for positive and negative ratings (dichotomized) range from 62% (for teacher and client) to 85% (for the psychologist and research assistant).

Analyses of responses to an open ended question about the reasons each youngster decided to participate (or not) in therapy provide an additional indication of understanding. The independent ratings of the two psychologists who reviewed the responses were highly consistent (88% agreement). Specifically, they agreed that 27 out of 35 participants manifested satisfactory understanding of the purposes of counseling. (Of the 8 who did not demonstrate adequate understanding, 5 mentioned only the fact that they felt forced into treatment and 3 gave irrelevant responses.)

Competence to communicate. Ratings of the youngsters' adequacy of communication present a less consistent set of findings. For instance, ratings by the psychologist at the end of the informed

consent interview indicate a mean of 2.8 (SD=.8). While not a particularly low rating, it is significantly lower than the psychologist's mean rating of the participants' understanding, $t(39)=4.69$, $p<.000$, and is significantly lower than the communication rating made by the research assistant following up on the informed consent process ($\bar{X}=3.5$, SD=.6), $t(32) = 4.67$, $p<.000$.

Comments. Data from this sample suggests most of the youngsters, including children as young as 10 years of age with histories of learning and behavior problems, appeared to demonstrate competence to understand and communicate effectively regarding their participation in psychological treatment. The fact that ratings of youngsters' communication generally were lower than rating of participants' understanding is seen as a specific indication of the importance of separating these variables in order to differentiate deficiencies in communication from poor ability to understand.

Question 3: Does informed consent indicate motivational readiness for treatment?

Measures of motivational readiness for treatment focused on degree of commitment, other initial attitudes toward treatment and current attitudes and behavior in other special intervention programs.

As direct measures of degree of commitment to treatment, we asked youngsters not only (a) whether they wanted to participate in counseling, but (b) when they wanted to start, and (c) to rate

how much choice they thought they really had about participating. Of the 42, 8 said they didn't want therapy (including some who refused even to answer any questions) and 3 others were uncertain. Of the 31 wanting therapy, only 25 wanted to start immediately. The Kendall's tau correlation between statements of wanting counseling and how soon the individual wanted to begin is .54 ($p<.01$).[1]

With regard to perceived choice, 74% of those consenting to therapy felt it was their choice ($\bar{X}=3.2$, $SD=1.0$).

To create an index of strength of commitment, the above data were combined with information about reactions to efforts to schedule a first meeting with the therapist. Using this index, 14 were categorized as having not given consent or as being "false positive" consenters, 15 were designated as having weak commitment, and 13 were seen as having strong commitment. The correlation between this index and participants' initial rating of wanting therapy is tau=.56 ($p<.01$).

Three other variables reflecting degree of commitment to treatment are intended effort, perceived need, and expected helpfulness. Youngsters ratings for each of these three variables are significantly correlated; the Kendall's tau

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1. There were a number of instances when a participant did not choose to respond to a specific measure; thus, in analyzing the relationship between any two variables, the numbers varied. Since a larger proportion of the nonresponders were those with negative attitudes, this probably reduced the variability and thus the magnitude of the correlations.

correlations range from .47 to .68 (all significant at $p<.01$). The internal validity of the youngsters' responses is supported further by the moderate correlations found between the index of strength of commitment toward therapy and positive statements about the amount of effort they intended to exert (tau=.42, $p<.01$) and the degree to which they expected treatment to be helpful (tau=.30, $p<.05$).

Finally, the index of strength of commitment was found significantly correlated with available measures of a youngster's motivation and negative behavior in the classroom (tau=.32, $p<.05$ and .40, $p<.01$, respectively), but not with on task classroom behavior. Ratings of intended effort and expected helpfulness of treatment also were significantly related to classroom motivation (tau=.39, $p<.01$, and .28, $p<.05$, respectively). (See Adelman & Taylor, 1983, for description of classroom measures and reliability data.)

Comments. Not surprisingly, the findings indicate that the youngsters (at all ages) varied significantly in terms of the strength of their commitment and initial attitudes toward treatment. The data underscore the point that informed consent is not tantamount to strong commitment. Thus, while informed consent is a critical prerequisite in an ethical context, it is not to be equated with motivational readiness for treatment. About 75% of this sample indicated willingness to participate in the proposed treatment. However, only 52% of those indicating verbal readiness appeared motivationally ready to begin

treatment. Statements of consent, then, probably are best viewed as reflecting a statement of volunteering. Perceived choice and level of commitment remain separate matters.

Question 4: How does initial strength of commitment relate to initial adjustment in treatment?

Initial adjustment in therapy was measured by therapist and client ratings, and the data were used to test the hypothesis that variations in youngsters' strength of commitment and other attitudes toward treatment are positively related to initial adjustment.

Degree of adjustment. Moderately positive mean ratings are found for all therapist and client ratings of initial adjustment in therapy (means range from 2.5 to 3.0 on a 4 point scale). Table 2 presents the correlations among the various ratings. As can be seen, the index of treatment effectiveness is related to therapist ratings of client effort and on task behavior. Therapist ratings are all significantly related to each other as are almost three-fourths of the 15 pairings of client ratings. There are, however, only three pairings of therapist and client ratings that are significant, and only the means for their respective ratings of effort (therapist $\bar{X}$ = 2.5, SD = .8; client $\bar{X}$ = 3.0, SD = 1.1) differ significantly, $t(31)=2.30$, $p<.05$.

Insert Table 2 about here

Relationship of antecedent variables to initial adjustment. Because of the limited variability in the therapist and client ratings on measures of initial adjustment, there are fewer significant group differences than were anticipated with reference to the hypothesized relationships. Nevertheless, where significant differences do occur, they all are consistent with the hypothesis that those with the strongest commitment and positive attitudes toward treatment make the best initial adjustment in therapy. For example, with regard to strength of commitment, the high, moderate, and low groups differ as hypothesized on (a) therapist ratings of client commitment (means are 3.1, 2.6, and 1.9, respectively), $F(2,31)=4.96$, $p=.01$, and (b) client ratings of effort (means are 3.8, 2.7, and 1.9, respectively), $F(2,29)=7.21$, $p<.003$, and (c) current wanting of treatment (means are 3.3, 2.2, and 1.9, respectively), $F(2,29)=6.09$, $p<.005$. Similarly, with regard to client antecedent statements of perceived choice, the high and low groups differ as predicted on client ratings of (a) effort put into therapy (means are 3.1 and 1.9, respectively), $F(1,27)=10.00$, $p=.004$, (b) perception of importance of therapy (means are 3.7 and 1.7, respectively), $F(1,27)=4.17$, $p=.05$, (c) therapy time spent on important matters (means are 2.9 and 1.9, $F(1,27)=4.09$, $p=.05$, and (d) current wanting of treatment (means are 2.7 and 1.7, respectively), $F(1,27)=4.76$, $p=.04$.

Similarly, the measures of classroom motivation, on task behavior, and misbehavior are positively related to initial

therapy adjustment. Those showing positive classroom motivation (as contrasted to those with low motivation) score higher on therapist ratings of effort (means are 2.8 and 2.2, respectively), $F(1,31)=4.47$, $p=.04$, and commitment (means are 2.9 and 2.1, respectively), $F(1,31)=7.28$, $p=.01$. The same pattern is found for the high, moderate, and low on task groups. Lastly, with regard to degree of misbehavior in class, those with fewer misbehaviors are significantly higher on therapist ratings of commitment (means are 2.9 and 2.2, respectively), $F(1,31)=4.88$, $p=.03$.

Analyses of demographic group differences indicate significant findings for therapist ratings of (a) effort (i.e., females and those 14 years of age and older were rated higher than males and younger clients), (b) on task behavior (i.e., anglos and those 14 and older were rated higher than nonanglos and younger clients), and (c) commitment (i.e., anglos were rated higher than nonanglos). No significant demographic differences were found for client ratings.

As can be seen in Table 3, correlational analyses further clarify interrelationships. For example, strength of commitment is found to be significantly related to 3 (of 6) client indices of initial adjustment and to the therapist rating of client commitment. Noteworthy among the other measures of clients' stated attitudes are perceived choice and intended effort (related to all client indices of initial adjustment) and expectation of treatment helpfulness (related to 4 of 6 client

indices and therapist ratings of client commitment). In contrast, measures of classroom motivation and on task behavior are related to a greater degree with therapist initial adjustment ratings (of client commitment and effort) than with self-ratings made by the clients. Similarly, the reports of classroom behavior problems are related significantly only to therapist ratings, i.e., of client commitment and on task behavior.

Insert Table 3 about here

Comments. Given the relative comparability of the means and standard deviations for the various ratings, the low correlations between therapist and client responses indicate major differences in stated perception between the two with regard to clients' early treatment attitudes and behavior. With regard to relevant criteria for investigating antecedent predictors of initial treatment adjustment, therapist ratings of client commitment and effort and youngster's actions, such as those reflected in indices of classroom motivation and on task behavior, were found to be the most promising variables. This is consistent with a variety of other research findings.

In general, the findings indicate a positive relationship between clients' motivational readiness for treatment and their initial treatment adjustment. At the same time, it is clear that antecedent motivation is but one of the primary factors affecting

initial adjustment. From this perspective, further areas for research include identification of factors which influence motivational readiness for treatment and those factors which inhibit, maintain, or enhance motivation for treatment during its initial stages.

Question 5: How do initial commitment and adjustment to therapy relate to short-term outcomes of treatment?

Three sets of data are available on short-term outcomes, i.e., (1) percentage of planned sessions attended, (2) end-of-treatment ratings and reports by therapists and clients regarding therapy process, progress, and effectiveness, and (3) end of treatment reports and ratings of motivation, on-task behavior, and misbehavior in the special classroom programs. The focus here is on the relationships of (a) antecedent commitment and other attitudes and (b) the quality of initial adjustment in therapy to short-term outcomes.

Analyses of variance and Kendall's tau correlations were computed to look at relationships between short-term outcomes and (a) strength of commitment at the onset of treatment, (b) other pretreatment indices of attitudes toward treatment, and (d) demographic variables.

While a different pattern of antecedent group differences emerge for the short-term outcomes (as contrasted to the relationship between antecedent and initial adjustment measures), the nature of the findings is the same. Because it is primarily the pattern of findings that are of interest, specific data

(i.e., means and significance levels) are provided only in the initial description of findings.

Specifically, significant group differences on measures of short-term outcomes were found for those who score high, moderate, and low on the index of initial strength of commitment for treatment; those more positively motivated scored higher on (a) therapist ratings of client commitment (means are 3.4, 2.5, and 2.0 respectively), $F(2,28) = 5.83$, $p<.01$, and (b) therapist ratings of client effort (means are 3.2, 2.5, and 2.3, respectively), $F(2,28) = 4.17$, $p=.03$, (c) client rating of effort (means are 3.7, 2.9, and 2.3, respectively), $F(2,22) = 4.61$, $p = .02$, (d) client rating of perceived importance of therapy (means are 3.3, 2.3, and 1.9, respectively), $F(2,22) = 3.55$, $p<.05$, (e) client rating of current wanting of therapy (means are 3.7, 2.3, and 1.6, respectively), $F(2,22) = 7.82$, $p<.003$, and (f) percent of complete sessions attended (means are 83%, 75%, and 50%, respectively), $F(2,38) = 6.24$, $p = .005$. They also differ in degree of misbehavior manifested in the classroom at the end of treatment, $F(2,34) = 7.34$, $p<.01$.

Moving on to the differences in short-term outcomes resulting from group differences in initial adjustment, it should be noted that the combination of high scores on the pre measures and the relatively small sample size undermined findings of significant mean differences for subgroupings. Nevertheless, high-low groupings on three initial adjustment variables yielded significant mean differences; the three variables are therapist

rating of client commitment and client ratings of effort expended in and satisfaction with treatment. Most promisingly, when therapist ratings of client commitment are divided into high vs. low groups, they differ significantly with regard to 9 of the 14 short-term outcome measures, i.e., (a) therapist end-of-treatment ratings of commitment and on-task behavior, (b) 5 of the 6 client ratings, (c) percent of complete sessions attended, and (d) the classroom index of misbehavior. Client initial adjustment ratings of effort and satisfaction divided into high vs. low groups yield significant differences, respectively, on six and four short-term outcome measures. Table 4 presents the Kendall's tau analyses.

Insert Table 4 about here

Comments. The findings from this phase of the research lend support to the view that better treatment outcomes result from strength of commitment and that the better the initial adjustment in treatment the better the outcomes. Stated in this manner, these findings may appear rather apparent and even mundane. However, the ease with which such matters can be stated belies the complex and profound issues involved in pursing research and theory related to factors that inhibit, maintain, or enhance individuals' motivation for overcoming their problems.

At this stage in the development of the field, it is imperative

that systematic, clinical research be undertaken to clarify relevant criteria and predictor variables associated with treatment motivation. In the present research, we did identify a number of outcome variables which can be useful as criteria in future investigations of potential predictors. These include the measures of therapist perceptions of clients' treatment attitudes, behavior, and progress, number of complete sessions attended, and clients' end-of-treatment self-evaluations. Some support for the accuracy of client ratings at the end of treatment comes from the data showing an increase in the number of significant correlations between therapist and client end-of-treatment statements. This increase in overlap is due to a slight downward shift in most client ratings -- from early to end-of-treatment -- which may be the result of statistical regression, a selective factor related to who remains in therapy, or a move toward more accurate statements. If the last is true, the lower self-ratings, paradoxically, may be another indication of treatment efficacy. With regard to predictor variables, the antecedent measures of client initial strength of commitment and of misbehavior and the initial adjustment ratings by therapists of client commitment and on-task behavior seem particularly promising.

Conclusions

There are times when excluding children and adolescents from decisions regarding psychological treatment is appropriate and necessary. However, the degree to which this is a common

practice in connection to referral to treatment in the sample studied seems excessive, unnecessary, and potentially counterproductive. Furthermore, the degree to which the desires of the few who did participate were ignored seems to go beyond concerns about competence to decide and is a poignant example of what is often the response to minors' views in such situations. It is clear that research in this area must focus not only on whether youngsters are present at decision making meetings but also must explore individual differences in competence and whether the input of minors is seriously considered.

The matter of which children and adolescents are competent to participate in psychological treatment decisions, of course, remains a difficult and controversial issue. A large proportion of those in the research sample certainly demonstrated a reasonable understanding of the psychological treatment being offered. They also demonstrated a satisfactory level of ability to communicate views about their involvement in such treatment. Whether they comprehensively understood the implications of participation or refusal to participate, of course, is uncertain (as it probably is for the majority of consenting adults). To further pursue this matter, we currently are engaged in research focused on evaluating children's ability to weigh the risks and benefits of proposed psychological treatment.

It is clear that a major implication of minors' participation in decision making is that they may decide against treatment that others feel is needed. Indeed, two of the six adolescents who

initially indicated a lack of desire for treatment (at the IEP meeting), subsequently chose not to participate when actually given the right to decide for themselves. This is an important (and oft cited) reason for excluding youngsters from decision making. However, perhaps equally important (yet relatively ignored) in this context are the negative psychological consequences of nonparticipation. Of particular concern is that excluded youngsters may have little or no commitment to use the prescribed treatment effectively and may even react quite negatively toward the activity. Some certainly will drop out, have themselves removed, miss sessions, or create diversions, as soon as they can effect such outcomes.

In general, the data reported converge in supporting the beliefs that there is a relative lack of participation of children and adolescents in referral processes and many who are not included do have the competence to participate in many key facets of treatment decision making. The research also highlights the hypothesized connection between participation in decision making and motivational readiness for treatment and provides data on the hypothesized positive relationship between motivational readiness and treatment adjustment and outcomes.

Despite the difficulty and limitations associated with clinical research samples, there is a clear need for investigations of the type reported here. Clinical practices and social policies for children and adolescents (e.g., judicial diversion programs) currently are formulated in the absence of an adequate body of

research and theory regarding the impact of variations in degree of involvement in treatment decision making. The risks, benefits, and limitations of youngsters' participation remain unsubstantiated. The concept of motivational readiness for treatment, if not ignored, often is reduced to the notion that readiness is a function of establishing rapport and a therapeutic relationship. Comprehensive, systematic approaches are yet to be formulated regarding how to enhance motivation for overcoming psychoeducational (including interpersonal) problems and how to reduce motivation for avoiding treatment. In pursuing any or all of these matters the questions arise: Is the decision to change central to the efficacy of psychological treatment and is participation in treatment decisions a key process in initiating and maintaining this decision?

Table 1

Key Measures

I. Understanding the purposes of psychological treatment

A. Structured questionnaire--Based on information provided during the informed consent process, four questions were asked regarding therapy purposes, frequency, and setting. Responses were scored as right or wrong.

B. Open ended question--"What are the major reasons you decided to participate or not in counseling?" If necessary, probes were used, e.g., "What are some things you think might be (good/bad) about participating?"

C. Self and other rating--Participants were asked "From what others (such as friends, your parents, and so forth) have told you about counseling, how much do you think you understand about what goes on in such meetings?" (1=not much--4=very much). Recontacted early in treatment, they were asked "How much of the time do you understand what the counselor says?" (1=a little of the time--1-15%--4=nearly all of the time--86-100%).

II. Communication

A. Understanding of verbal communication--Based on their interactions with a youngster, the psychologist who conducted the informed consent interview, the research assistant conducting the study of reactions to the consent process, and the youngster's classroom teacher (prior to treatment), as well as the youngster's therapist (early in treatment), directly rated the degree to which a youngster understood information given verbally. Rating alternatives were 1=poor, i.e., understands little or none (0-15%) of the information--4=excellent, i.e., understands almost all or all (86-100%) of the information.

B. Adequacy of communication--Prior to treatment, the same individuals were asked to judge how well the youngster communicated by rating 1=poor (great deal of problem communicating--86-100% of the time)--4=excellent (no problem or little problem--0-15% of the time). Early in treatment, along with other reactions to treatment, each client was asked "How much of the time does your counselor understand what you try to say?" (1=1-15% or a little of the time -- 4=86-100% or nearly all of the time).

III. Initial Strength of Commitment Index

A. Low group--outright refusal during consent interview, avoidance of scheduling, not attending, or immediate drop out in first or second session;

B. Moderate group--consent responses of "maybe" or "yes but" with major conditions or with complaints of being compelled to consent (e.g., by parents);

C. High group--unconditional and uncomplaining affirmative responses.

IV. Antecedent attitudes toward psychological treatment

A. Intended effort--"How much effort do you think you (will/would) put into such meetings?" Response alternatives range from 1=not much to 6=as much as possible;

B. Perceived need--"How much do you think you need help with your problems?" (1=not much to 4=very much);

C. Expectation of helpfulness--"From what you know about counseling, how helpful do you think such meetings might be for you?" (1=not helpful to 4=very much helpful).

V. Therapist ratings

A. Client on-task behavior--"Estimate the percent of time on-task for your client. On-task is defined as time spent in ways relevant to agreed upon objectives" (1=0-15% of time on task -- 4=86-100% time on task);

B. Client commitment--rating from 1 = little or no commitment to therapy process (misses appointments, comes late, sullen, no interest in relating to therapist) to 4=high commitment (attends regularly, focuses on problems, very interested in relating to therapist);

C. Client effort--rating from 1=exhibits little effort toward dealing with problems to 4=considerable effort expended in focusing on problems;

D. Effectiveness of Treatment Index--rating of progress on up to three treatment objectives ranging from 1=poor progress (movement toward objective much less than expected for this objective and this client)--4=excellent progress (very rapid

movement toward achieving objective); ratings were averaged.

VI. Client's ratings

A. Effort--"How much effort do you put into counseling?"

B. Personal importance of treatment--"How important is it to you to be able to go to counseling this year?"

C. Time spent on important matters--"How much of the time in counseling do you spend talking about what you and the counselor agree are important areas?"

D. Degree of progress--"How much progress do you feel you're making in counseling in general?"

E. Degree of satisfaction--"How satisfied are you with counseling?"

F. Degree of wanting treatment--"At this time, how much do you want counseling?"

Table 2

Correlations Among Therapist and Client Ratings of Initial Adjustment

	Commitment (th. rat.)	Effort (th. rat.)	On task (th. rat.)	Effectiveness (th. rat.)	Effort (cl. rat.)	Import. of ther. (cl. rat.)	Time on import. matters (cl. rat.)	Want ther. (cl. rat.)	Satis. (cl. rat.)	Progress (cl. rat.)
Commitment (therapist rating)		.67**	.49**	.28	.40**	.14	.36**	.16	.06	.01
Effort (therapist rating)			.56**	.38*	.29*	.02	.08	.03	-.06	-.07
On task (therapist rating)				.33*	.08	-.15	.14	.05	.02	-.05
Effectiveness (therapist ratings)					.20	.14	.06	.27	.09	.04
Effort (client rating)						.50**	.47**	.52**	.24	.27*
Importance of therapy (client rating)							.23	.57**	.15	.20
Time on important matters (client rating)								.39**	.42**	.38**
Wanting therapy (client rating)									.49**	.32*
Satisfaction (client rating)										.49**
Progress (client rating)										

*p < .05
**p < .01

Table 3

Correlations Among Ratings of Client Attitudes/Behaviors Prior to Treatment and Therapist and Client Ratings of Initial Adjustment to Treatment

Initial Adjustment	Misbehavior (classroom)	On task (classroom)	Motiv. index (classroom)	Strength of Commit. index (th.rat.)	Wanting Therapy (client rating)	How soon (cl. rat.)	Perc. choice (cl. rat.)	Intended effort (cl. rat.)	Expected help (cl. rat.)	Perc. need (cl. rat.)
	Prior to Treatment									
Commitment (ther.rating)	.35*	.26*	.40**	.42**	-.04	.07	.01	.22	.26*	.16
Effort (ther.rating)	.18	.28*	.32*	.21	.00	.13	-.03	.14	.24	-.19
On task (ther.rating)	.31*	.07	-.15	.14	.00	.16	.06	-.11	-.03	-.39**
Effectiveness of therapy index (ther.rating)	.02	.06	.04	-.02	.07	-.01	.10	.10	.14	.01
Effort (client rating)	-.05	.09	.29*	.51**	-.05	.00	.50**	.47**	.50**	.28*
Import. of therapy (client rating)	.00	-.14	.08	.23	-.03	.02	.37**	.41**	.44**	.38**
Time on imp. matters (client rating)	.13	.03	.06	.21	-.08	-.04	.47**	.38**	.33*	.16
Wanting therapy (client rating)	-.02	-.07	.04	.47**	.16	-.12	.37**	.34*	.25	.19
Satisfaction (client rating)	.02	.02	.02	.28*	-.04	-.27*	.28*	.38**	.20	.12
Progress (client rating)	.26	.19	-.04	.26	-.01	-.12	.31*	.45**	.32*	.15

*p < .05
**p < .01

Table 4

Correlations Among Indices of Initial Adjustment to Treatment and End-of-Treatment Indices of Short-term Outcomes

Short-term Outcomes	Initial Adjustment: Commitment (th. rat.)	Effort (th. rat.)	On task (th. rat.)	Effectiveness (th. rat.)	Effort (cl. rat.)	Import. of ther. (cl. rat.)	Time on import. matters (cl.rat.)	Want ther. (cl. rat.)	Satis. (cl. rat.)	Progress (cl. rat.)
Commitment (ther.rating)	.46**				.44**	.38**	.39**	.46**	.42**	.28*
Effort (ther.rating)	.34*	.35*	.26*		.27*			.42**	.44**	.32*
On task (ther.rating)	.28*	.41**	.44**							
Effectiveness (ther.rating)	.38*	.45**		.32*						
Effort (cl.rating)	.48**				.43**	.29*				
Importance of therapy (cl.rating)	.43**				.41**	.38*				
Time on import. matters (cl. rating)										
Wanting ther. (cl.rating)	.31*				.48**	.41**		.54**		
Satisfaction (cl.rating)					.29*					
Progress (cl.rating)					.46**	.34*		.32*	.44**	.38*
Complete sessions attend.										
Misbehavior (classroom)	.47**				.49**					
On Task (classroom)	.33*				.29*					
Motivation (classroom)	.35*									

*p <.05

**p <.01

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